LOCALITY PLAN 2024

Girvan and South Carrick

south ayrshire
health & social care
partnership

SOUTH AYRSHIRE LOCALITY PLANNING

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Strategic Context

In 2021 the South Ayrshire Health and Social Care Partnership (SA HSCP) published it's 10 year **Strategic Plan 2021-31**.

Within this strategy there are 7 strategic objectives:

Crucial to delivery of the strategic plan are the values of empowerment, compassion, openness and respect, with a clear commitment to co-production and co-design reflected within the South Ayrshire Wellbeing Pledge:

Locality planning is a key vehicle for ensuring that the voice of local communities' shape wellbeing, services and support across South Ayrshire, in line with population data, national and local policy context and professional advice.

Locality Planning is a requirement of the Joint Bodies Act which underpins integration of health and social care, and an essential mechanism to this is the formation, maturation and delivery of the Locality Planning Partnership (LPP) within the Girvan and South Carrick locality.

Through communication and engagement with stakeholders, evidence base and extensive analysis of population data the Girvan and South Carrick LPP has identified 5 priority areas;

- Tackling social isolation and loneliness.
- Promoting good mental health wellbeing and physical health.
- Managing long term health condition.
- Tackling drug and alcohol issues.
- Support unpaid carers in the community.

To demonstrate progress in relation to the 5 priority areas a 1 year bridging locality plan has been agreed. This plan represents a clear evidence base, aligned to population data, national and local drivers, professional advice and lived experience, and articulates the aspirations of the Girvan and South Carrick Locality.

The plan adopts a strength based and compassionate approach, recognising the importance of partnership working, the dedication and professionalism of the workforce, and the resilience and civility across the locality.

Girvan and South Carrick Locality Profile

Some of the key points of the Girvan and South Locality population data are summarised below:

- A total population of **9,259** people, where **47.9%** were male, and **27.6%** were aged over 65.
- **0%** of people lived in the least deprived SIMD quintile, and **22.9%** lived in the most deprived quintile.
- Service access is a significant issue for almost **50%** of the population of Girvan & South Carrick
- An average life expectancy of **75.3** years for males and **81.5** years for females, compared to the Scottish average of **76.5** and **80.7 years** respectively.
- A death rate for ages 15 to 44 of **149 deaths per 100,000** age-sex standardised population (**117 deaths per 100,000** for Scotland).
- **28.7%** of the locality's population with at least one long-term physical health condition. This is higher than Scotland (**21.7%**).
- A cancer registration rate of **620.4** registrations per 100,000 age-sex standardised population (compared to **630.3** in Scotland).
- **26.8%** of the population being prescribed medication for anxiety, depression, or psychosis. This is a larger proportion than Scotland (**20.1%**).
- **13,414** emergency hospital admissions per 100,000 population, compared to **10,367** in Scotland.
- **159,412** unscheduled acute specialty bed days per 100,000 population, compared to **77,178** in Scotland.
- **105.473** delayed discharge bed days per 100,000 population aged over 65, compared to **50,362** in Scotland.
- **2,150** emergency hospital admissions from falls per 100,000 population aged over 65, compared to **2,283** in Scotland.
- **99.4** emergency readmissions (28 day) per 1,000 discharges, compared to **102** in Scotland.
- **2,408** potentially preventable hospital admissions per 100,000 population, compared to **1,638** in Scotland.
- **988.3** alcohol-related hospital admissions per 100,000 age-sex standardised population. This is higher than Scotland (**611.1** admissions per 100,000).
- **11.9** alcohol-specific deaths per 100,000 age-sex standardised population. This is lower than Scotland (**21.1** deaths per 100,000).
- **331.4** drug-related hospital admissions per 100,000 age-sex standardised population. This is higher than Scotland (**228.4** admissions per 100,000).

A fuller analysis of the locality profile data is available on request.

Locality Priorities

As part of locality planning, a communication and engagement plan was implemented order to identify locality priorities. This approach was approved and supported by LPP members.

An online and paper-based survey was circulated widely though our distribution lists, social media platforms and through partners and LPP members:

- Overview of the LPP.
- Locality Profile.
- Overview of the priorities and how they are formed.
- List of potential priorities.
- Question asking what we can do differently/in addition to what we are currently doing.
- Question asking if they would like to be a member of LPP.

This approach complimented discussion at the LPP, and consideration of Public Health Scotland profile data, wider strategic priorities, national and locality policy drivers and professional advice.

Following the feedback from the survey, and ongoing discussion at the LPP it was agreed that the following 2023/2024 priorities would be:

- **Tackling social isolation and loneliness.**
- **Promoting good mental health wellbeing and physical health.**
- **Managing long-term health conditions.**
- **Tackling drugs and alcohol issues.**
- **Support unpaid carers in the community.**

Community Planning

On setting key strategic themes, the South Ayrshire Community Planning Partnership's Local Outcome Improvement Plan affirms the interdependency on place and wellbeing.

By adopting a truly whole system and whole family approach beyond the services directly delivered by the SAHSCP the locality plan will ensure priorities and actions

identified are intrinsically linked to the following Strategic Delivery Partnerships (SDPs):

- Children's Services Planning Partnership.
- Community Safety Partnership.
- Financial Inclusion and Growth.
- Population Health.
- Sustainability.

Essential to this will be the membership and delivery of the LPP, ensuring that there is representation linked to key priority areas.

The Girvan LPP consists of a range of stakeholders working collaboratively across the locality; representation from local community services, community councils, HSCP, community planning, third sector and independent sector.

Aligned to the LPP are clear terms of reference to ensure the communities voice is heard, and that all stakeholders are working together to plan for, resource and provide services, support and care in the local area, with a focus on tackling inequalities.

It is envisaged through whole system partnership working, co-production and co-design this locality plan will articulate actions relevant to locality priorities with a clear, authentic and transformational approach aligned to quality planning, improvement and assurance.

Clear governance and reporting arrangements with regards to locality planning, health and care and community planning will enable recognition of progress to date, and a focus on the learning and improvements required.

For 2023-2024 the locality plan will move towards a place-based approach, ensuring clear synergy and alignment to place and wellbeing.

In addition, there will be synergy with the Community Learning and Develop (CLD) Plan. In South Ayrshire, Community Learning and Develop (CLD) provision is coordinated by the CLD partnership. The CLD partnership has the strategic responsibility for developing a CLD Plan every three years, this plan sets out the strategic priorities and a local level this is coordinated by the CLD Learning Community Partnerships.

Although CLD is led by officers from Thriving Communities the partnership includes representation from Health and Social Care Partnership, Skills Development Scotland, DWP, Voluntary Action South Ayrshire, Ayrshire College and Community Planning Partnership. The current plan has five main priorities these include:

- Youth Work – Improving Outcomes for young people.
- Mental Health and Wellbeing – Building healthier communities.
- Employability and Volunteering – Supporting Communities to progress.

- Adult and Family Learning – Improving outcomes for adults and families.
- Community engagement and empowerment – supporting our communities to thrive.

This synergy will create opportunities to maximise resources, align local needs and priorities and co design services with communities. This is further enhanced by locality teams working together within communities.

The CLD Plan 2021 – 2024 will be refreshed in September 2024 following consultation with learners, communities, partners and the CLD workforce.

To promote community empowerment there will be participatory budgeting opportunities for locality citizens and groups to access. The expectation will be that participatory budgeting will be linked clearly to the locality priorities and there will be regular communication and networking events to raise awareness of local groups/initiatives and how these can be accessed.

This approach will foster an asset-based community approach, build on the resilience already evident in the locality and sit nicely with the principles of community led support.

Opportunities

There are a number of opportunities where synergy with implementation and delivery of the locality plan is integral.

The following will align with the bridging plan and future iterations, and discussion and planning will be mirrored within the HSCP Driving Change Programme;

Caring for Ayrshire - enabling people to access high quality primary and community care closer to home.

Ageing Well Strategy – recognising the older population within the locality, and the value they bring to communities and families, embedding actions that will support older adults to live as independently as possible.

Mental Health and Dementia Strategies – refreshing local strategy in line with national strategic direction, and ensuring linkage with locality plans and priorities.

Digital Strategy – linking locality planning and care delivery towards a future where technology and data are seamlessly integrated into operations, service delivery, and decision-making processes, and empowering individuals to feel more empowered to ownership and control of their care, wellbeing and independence.

Alcohol and Drug Partnership (ADP) – building on the strong partnership working across the ADP and working together to ensure citizens affected by alcohol and/or drugs receive the support which meets their needs, when they need it.

Focus on Frailty Programme – partnership working to improve the experience of and access to person centred coordinated care for adults living with frailty or at risk of frailty.

Care at Home Strategy – linking existing and new models of care to commissioning arrangements, recognising the relevance of locality demographics across Girvan and South Carrick.

Adult and Young Carer Strategies – ensuring that carers are recognised, valued and supported.

As part of driving change and locality planning, and to ensure a quality management approach, there will be emphasis on quality improvement and management with respect of planning, improvement and assurance. To support this approach the workforce have access to electronic and participatory training to aid learning and utilisation.

Building on the strengths

It is vital to recognise, celebrate and build on the strengths across the locality, whilst maintaining humility around learning and continuous improvements. Below is a summary of strengths across the locality that will aid progress and realisation of the locality plan;

- A wellbeing pledge with emphasis on co-production and co-design.
- A continued focus on delivery of services in line with statutory requirements.
- Training and development of staff in line with the principles of community led support.
- Provision of community health workers and link practitioners across GP practices.
- Embedded Multi-Disciplinary Team approach across Girvan with focus on hospital in-patient and hospital avoidance.
- Community assets placed throughout the locality.
- Resilient communities evidenced through appetite to engage in participatory budgeting and community development opportunities.
- Positive third sector interface.
- A Mentally Healthy Communities Toolkit and action plan.
- In the past year many health and care services such as Day Care, Care at Home, Reablement and Adult Services have received positive inspections and grades.
- Commitment from LPP members, with broad mix of community and service representation.
- Girvan community hospital. *****

Girvan Community Hospital *

Girvan Community Hospital opened in 2010 and currently hosts two GP Practices, a Rehabilitation Suite, a minor injuries facility, outpatient facilities, a canteen, conference rooms and a small in-patient facility. In addition it hosts a Scottish Ambulance Service base, a Police Scotland Base, a local Community Pharmacist and is the office base for number of partnership staff.

It is acknowledged that the site is a community asset, wherein every day there are good examples of multi-agency, coordinated working that links primary, community and secondary care service provision to wider community supports and partners.

Cognisant of; a changing landscape, opportunities linked to technology and care closer to home, and the locality priorities, for 2023/24 there will be a review of the site.

This approach will build on the strengths already evident within the site and look at areas such as sustainability of the minor injury unit, and the aspiration that delivery of the unit aligns with patient pathways to ensure that any follow up required after attendance at the unit is seamless.

It is proposed that the review will be in conjunction with the Caring for Ayrshire Strategy looking at care delivery closer to home and at a more locality based level.

Within scope of this review will be discussion and potential testing with regards community hubs, enhanced multi-disciplinary working, day care, secondary care provision, increased diagnostics and use of technology and it is envisaged that the development of the Team around the Locality Model will provide context and a natural fit to improvement opportunities within the site.

Team around the Locality

A key focus for the locality, and the golden thread throughout delivery of the locality plan, will be the design and implementation of the Team around the Locality model.

The HSCP Locality Management Team will be working in partnership with the locality and stakeholders to shape and deliver services to empower individuals and communities to start well, live well and age well.

The objective of the model will be to connect practitioners and people from health, social care, independent sector, the voluntary sector, and the community with a focus on the needs of individuals and their local community.

Within the model is a vision that includes integrated hubs serving as a convenient point of access for individuals seeking support. These hubs will provide information, advice, assessment, treatment and various support services all in one local location.

The model will be based on the following principles:

- **Person centred**; Engage individuals in thoughtful dialogue and joint decision making. Providing the information, advice, and support needed to protect their independence.

- **Building local capacity**; strengthening local community capacity, promoting local responses, including volunteering and developing micro-enterprises.

- **Partnership working**; fostering strong partnerships with the local community as well as with teams, partners and independent organisations.

- **Integrated care**; striving for coordinated, collaborative services that cater to specific needs and promote the wellbeing of local communities.

- **Community engagement**; active engagement with local residents to collectively shape services and support to address the needs of the local community.

- **Quality improvement**; integrating quality improvement approaches into our work, ensuring we provide the best outcomes for our communities.

- **Prevention/early intervention**; ensuring timely access to information, advice, and support, promoting independence and ageing well.

- **Strength / asset-based assessment**: building upon the strengths of individuals, their families, and the communities that support them to live well.

The Team around the Locality model will bring into line clear alignment of support and care for individuals in the locality ranging from community led focus on prevention, early intervention and supported self-management to coordinated and integrated supports for adults with complex care needs.

The model will be aligned to clinical standards, evidence-based practice, professional development and staff governance to ensure that the workforce are prepared, competent and confident. This will mirror recognition within the NHS Staff Governance Framework that the workforce must be well informed, involved in decision making, appropriately trained and developed, treated fairly and with respect, and working within a safe environment.

Fundamental to this approach across the locality and plan will be psychological safety and a culture where all key stakeholders are encouraged to be curious with a focus on learning and continuous improvements.

Workforce

Our workforce are our greatest asset.

To inform pending and effective implementation and delivery of the Team around the Locality model and other relative actions within the locality plan, a recent workforce engagement event took place in Girvan. At the event there was attendance from HSCP, community planning, third sector and independent sector partners.

The objective of the event was to bring key stakeholders together to inform and be part of future planning across the locality cognisant the importance of workforce engagement, and creating the culture and conditions for collaboration, learning and improvements.

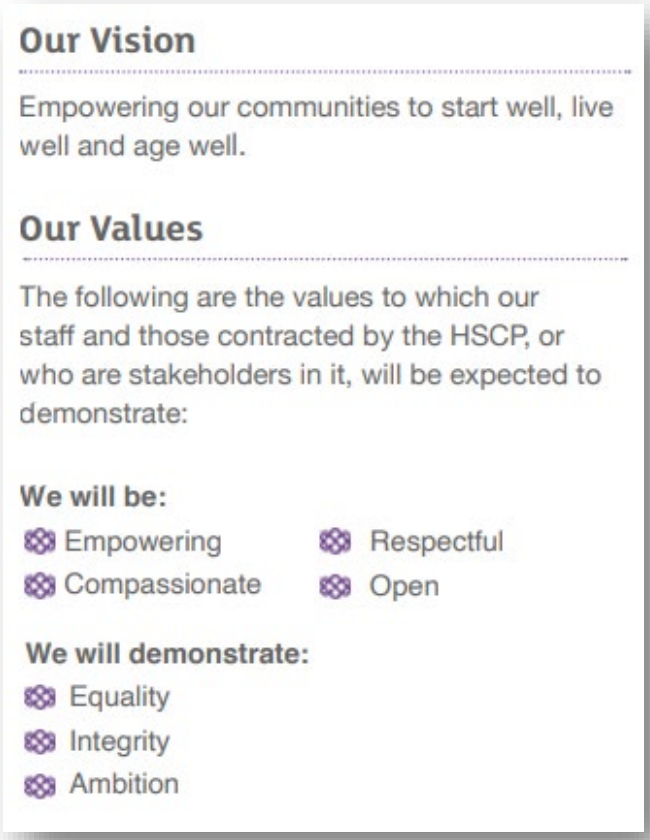
Key items covered within the event were as follows;

- Celebrating success and strengths across South Ayrshire, and the Girvan / South Carrick Locality.
- Networking of key stakeholders.
- Awareness and discussion with regards to locality population profile data.
- Awareness of the Team around the Locality Model.
- Identification of short-term wins to enhance partnership working across the locality.
- Discussion and planning for future implementation of the Team around the Locality Model.

From discussion key themes have emerged which in turn have helped to inform present and future plan within the locality;

- Better networking and services linking in.
- Hubs / one stop shop for people to access services.
- Transport links to increase accessibility of services.
- Better access to information of what is available in locality.
- Empowering people to take more responsibility for their own health and wellbeing.
- Social groups within the locality to decrease social isolation.
- Decrease stigma around substance abuse.
- Improve IT systems to ensure work is being linked up.

Ongoing workforce development, as aforementioned, is pivotal to the ongoing delivery of safe and effective care in line with Healthcare Quality Strategy and National Health and Care Standards. This in turn will ensure effective implementation of this plan in line with professional standards and best practice. Key to this will be clear development plans and supervision arrangements for HCSP locality staff, aligned to professional registration requirements.



Workforce planning and development is a key pillar for delivery of the locality plan. To ensure effective implementation of the plan there will be ongoing delivery with regards the key components of the SA HSCP Workforce Plan 2022-2025; plan, attract, train, employ and nurture.

Crucial to this will be the vison and values across the locality, asking all stakeholders to be mindful of and model compassion, respect and openness. Fundamental to the plan is a workforce that is informed and engaged, skilled and digitally confident, valued, ambitious and proud, and collaborative.

Recognising the rurality of the locality there will be opportunities within the plan to explore and expand on newer models of care to complement existing practice such as micro-enterprises wherein support can be given to local people to set up small enterprises that offer care-based support services that are person centred and give more choice and control.

In addition, it is expected that all HSCP staff have an awareness and understand of the Quality Improvement methodology to support quality management approaches to transformational change. This is achieved through e learning, attendance at board level found courses and / or attendance at national level training.

Action Plan

The following action plan identifies key priorities linked to strategic objectives, actions, measures and the wellbeing pledge.

It is envisaged that the plan will be driven by the LPP and reported on a frequent basis to the relevant committees and forums;

Key (wellbeing pledge links)

 Support families to ensure their children have the best start in life.	 Provide services around you and your family.	 Help communities to connect and care for each other.	 Ensure people have the information they need to support their health and wellbeing.
 Listen to you and support you to take control of your own care.	 Support people to age well by keeping them healthy and in their home for as long as possible.	 Give you information on how you can keep active and well.	 Be open, honest and friendly.

Promoting good mental health wellbeing and physical health

Actions	Measures	Link to Wellbeing Pledge
Establish a front door social work (SW) service incorporating a preventative / early intervention approach.	Reduction in unallocated SW waits.	
Embed a community led support approach across community health and care.	Number of staff trained. Learning from National Development Team for Inclusion (NDTi) / Impact sessions.	

Promotion of the Mentally Healthy Toolkit and action plan.	Percentage of people prescribed medication related to anxiety, depression or psychosis.	
Review of Girvan Community Hospital site, inclusive of minor injury unit sustainability.	Number of emergency admissions. Number of unscheduled bed days. Number of potentially avoidable admissions.	
Sustainability of multi-disciplinary meeting within Girvan, and linkage to frailty work stream.	Number of emergency admissions. Number of unscheduled bed days. Number of potentially avoidable admissions.	
Increase awareness of suicide prevention through training for staff and communities.	Number of deaths related to suicide. Number of deaths between ages of 15-44.	
Develop closer links between community health and care, and mental health services through induction, shadowing, role modelling, enhanced multi-disciplinary working and exploration of hubs.	Number of emergency admissions related to psychiatry. Number of unscheduled bed days.	
Ensure that every HSCP staff member has a personal development plan in place.	Number of personal development plans. iMatters (staff engagement tool).	

Managing long term health conditions

Actions	Measures	Link to Wellbeing Pledge
Focus on improvement work with regards use of technology to support self-management of long term conditions, aligned to Caring for Ayrshire work streams and Digital Strategy.	Number of emergency admissions. Number of unscheduled bed days. Number of potentially avoidable admissions.	
Sustainability of chronic disease monitoring as per primary care improvement plans.	Number of potentially avoidable admissions.	
Coordinate a health improvement campaign calendar in partnership with library services and health improvement.	Number of long-term conditions.	
Focus on improvement work aligned to the Frailty Programme.	Number of potentially avoidable admissions. Number of emergency admissions.	
Increase the number of microenterprises delivered within the locality.	Number of micro-enterprises.	

Tackling social isolation and loneliness

Actions	Measures	Link to Wellbeing Pledge
6 monthly locality engagement and networking events, inclusive of community planning and community groups, to foster greater awareness and links to supports in the locality.	Mapping of assets and supports across the locality.	
Ongoing close working with third sector to identify risks and develop supports.		
Use of participatory budgeting to tackle isolation such as chatty spaces and activities.		

Tackling drug and alcohol issues

Actions	Measures	Link to Wellbeing Pledge
Develop closer links between community health and care, and alcohol / drug services through induction, shadowing, role modelling and enhanced multi-disciplinary working.	Reduction in alcohol and / or drug related admissions. Drug related deaths.	 
Explore and implement supports wherein citizens with alcohol and / or drug problems can access timely support, possibility of alignment of front door SW hubs and alcohol / drug access points.	Reduction in alcohol and / or drug related admissions. Drug related deaths. Medication assisted standards.	

Relevant drug and alcohol training available for community health and care staff.	Drug related deaths. Adult protection timescales and performance.	

Support unpaid carers in the community

Actions	Measures	Link to Wellbeing Pledge
Annual carers event to thank carers for their dedication, and to foster greater awareness of supports available for carers in the locality.		
Increase staff awareness of carers through self-assessment and delivery of Triangle of Care.		

Governance

Good governance is essential, and the Locality Plan will follow the governance principles set out in the NHS Scotland Blueprint for Good Governance. It is vital there is a clear mechanism for evidence, assurance and improvements.

The Locality Plan will align with HSCP, NHS board and council governance arrangements.

With regards to the Locality Plan there will be regular interface and updates via the community planning structures.

HSCP governance

As set out in the Strategic Plan transparency, listening and integrity are vital to the success of care and support across the locality. This approach is enshrined throughout the wellbeing pledge.

As such, integral to the actions and measures outlined above, will be constant feedback from citizens, the locality and the workforce through mechanisms such as Care Opinion and iMatters.

In addition, the progress of the plan and actions within, will align to partnership governance arrangements and areas such as complaints handling, adverse events, inspection visits, reports and themes.

It is envisaged that key HSCP work around Delayed Transfers of Care and Community Services Oversight will line with actions relevant to the Locality Plan and LPP thus ensuring the communities voice is heard at all times.

To ensure locality plans and the Local Outcome Improvement Plan are integrated, the Senior Manager for Localities Senior Managers will attend the SDP Chairs Executive Group – a key executive group reporting to the Community Planning Board.

This approach will develop future locality models and plans to complement the LOIP and encourage:

- A simpler, more joined up local system that offers the right support at the right time that manages the growth in demand and to reduce duplication in the system;
- Integrated, multi-disciplinary teams from across the public sector working together on the same geography and tackling issues holistically, focused on relationship-building and getting to the root causes;
- A workforce who feel connected to each other and able to work flexibly, better able to meet people's needs; and
- A new system partnership with the voluntary sector to co-ordinate local activity, networks and opportunities – so that we make the best use of the strengths and assets of our communities.